Cancer Surgery Standards Program (CSSP) Case Identification Guidelines
CoC Standard 5.6: Colon Resection

Note: Standards 5.3–5.8 do not require an internal audit to be compliant with the standard. However, this is recommended to identify any gaps in compliance.

Rationale: These guidelines can help CoC-accredited programs identify and/or audit their cases as they begin to track compliance with the surgical standards.

Standard 5.6 Colon Resection

Standard 5.6 applies to surgical cases starting January 1, 2023. Registrars can use the surgery codes in STORE as an efficient way to identify cases for the surgical standards, along with other items listed under the general guidelines below.

Scope of Standard

This standard applies to all resections performed with curative intent for patients with colon adenocarcinoma, and applies to all operative approaches. *Note: This standard does not include appendix primaries.*

Measure of Compliance

Each calendar year, the cancer program fulfills the compliance criteria:

1. Resection of the tumor-bearing bowel segment and complete lymphadenectomy is performed en bloc with proximal vascular ligation at the origin of the primary feeding vessel(s).
2. Operative reports for resections for colon cancer document the required elements in synoptic format.

Synoptic Operative Report Requirements

There are currently three (3) elements that require a response in a synoptic format. These are listed in the *Optimal Resources for Cancer Care (2020 Standards)*.

General Guidelines and Source Documents:

Programs can audit for compliance or prepare for the site visit using the following steps:

- ✓ Using the Cancer Registry database - Pull cases within the scope of the standard with the following criteria:
  - Patient identifiers (MRN, Accession year [2023 and >], Class of case)
  - Surgeon identifiers (NPI, physician code, etc.)
  - Year surgery performed
  - Surgery performed at repoint facility
  - ICD-0 Primary site codes (C18.0 – C19.9, excluding Appendix, C18.1)
  - Surgery codes B291 – B900 from STORE
- ✓ Using the EMR - Review the Operative Report to determine the following:
  - Curative or palliative intent
  - Tumor location is noted
  - A synoptic format is used in the operative report and includes the current required data elements and responses according to Standard 5.6

Site Visits

2024 site visits will evaluate charts from 2023 to determine whether 70% of operative reports within the scope of this standard meet the requirements for Standard 5.6. The compliance rate will increase to 80% beginning with 2025 site visits (which will review 2023 and 2024 operative reports). Site reviewers will review 7 charts for this standard.